DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185378	B. WING		03/04/2015	
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 000	INITIAL COMMENTS	3	F 00	0		
F 226 SS=D	and concluded on 03 KY22912. The Division unsubstantiated the adeficiencies cited. 483.13(c) DEVELOP ABUSE/NEGLECT, If The facility must devipolicies and procedumistreatment, neglection in the procedumistreatment.	on of Health Care allegation with related //IMPLMENT ETC POLICIES elop and implement written	F 22	6		
	by: Based on interviews policy review, it was					
	2014, revealed on paitem number seven (allegation of abuse, radministrator would Community Based Sthe Inspector General crime had been community Based Sthe Inspector General Crime had been communities and the facility notifications would be of the facility notifications.	's Abuse Policy, revised July age four (4) of six (6) under 7) revealed if there was an neglect, or exploitation, the notify the Department for ervices (DCBS), the Office of al (OIG), and if a suspected mitted, the local police. e made within two (2) hours tion.				
	-	's investigation conducted on				
ABURATORY	DIKECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	₹ E	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/16/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100386

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185378	B. WING _				04/2015
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066	:	001	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	abuse of Resident #1 DCBS or the OIG had allegation. Interview with Assista 03/03/15 at 2:05 PM, notified of the alleged against Resident #1 k Assistant (CNA), a viction (2) students and interviewed, the incidical Administrator and no taken by the facility to addition, she stated the DCBS and OIG were. Interview with the Administration of the allegation came to the unsubstantiated and notified. In addition, hidirected that DCBS at 483.75 EFFECTIVE ADMINISTRATION/R. A facility must be administration of the unsubstantial and notified. In addition, hidirected that DCBS at 483.75 EFFECTIVE ADMINISTRATION/R. A facility must be administration of the unsubstantial and notified and notifie	ation of the alleged physical revealed no evidence that a been notified of the and Director of Nursing, on revealed when she was incident of physical abuse by a Certified Nursing deo was reviewed, staff and their instructor were ent was reported to the futher action had been a notify DCBS or OIG. In the Abuse Policy did state the to have been notified. In ministrator, on 03/03/15 at the viewing the video, he and alleged physical abuse a decision the incident was DCBS, not OIG, were the stated the Abuse Policy and OIG were to be notified. ESIDENT WELL-BEING In ministered in a manner that assources effectively and maintain the highest mental, and psychosocial		226			
	by:	is not met as evidenced and record review, it was					

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		185378	B. WING		C 03/04/2015		
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 11 FRANKFORT ROAD SHELBYVILLE, KY 40066	03/04/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ON SHOULD BE COMPLETION IE APPROPRIATE DATE		
F 490	Abuse Policy which is appropriate agencies suspected Abuse wh abuse towards Resid facility. The findings include: Review of the facility 2014, revealed the DB ased Services (DCI Inspector General (CI local Police Departm Review of the facility physical abuse again revealed no evidence OIG had been notified Interview with the As on 03/03/15 at 2:05 F staff member to who	ristrator failed to follow the stated to notify the en an allegation of physical lent #1 was reported to the lent #1 was reported to the repartment for Community as), the Office of the ent were to notified. It is investigation of an alleged lest Resident #1 on 02/25/15, was available that DCBS or dof the allegation. Sistant Director of Nursing, PM, revealed she was the more than the allegation of physical	F 490	,			
	local school's Clinical had only reported the Administrator and the She stated, she had Interview with the Ad 3:40 PM, revealed the allegation had been the stated the facility however, could not sand therefore did not DCBS or OIG. In adopolicy stated to report	orted to. This was done by a I Instuctor on 02/25/15. She is allegation to the is Social Services Director. In not notified DCBS or OIG. Iministrator, on 03/03/15 at it is alleged physical abuse reported to him on 02/25/15. Investigated the allegation; is ubstantiate the allegation to interport the allegation to dition, he stated the facility it any alleged allegation of it, and if applicable the Local					

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